STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 00 B. WING	01/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE RETIREMENT HOME	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

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F0000		F0000		

This visit was for Investigation of Complaint IN00101601.

Complaint IN00101601 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.

Survey dates: January 12 and 13, 2012

Facility number: 001144
Provider number: 155668
AIM number: 200256980

Survey team: Jennie Bartelt, RN

Census bed type:
SNF: 53
SNF/NF: 59
Residential: 9
Total: 121

Census payor type:
Medicare: 19
Medicaid: 39
Other: 63
Total: 121

Sample: 3

This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 1/17/12 Cathy Emswiller RN			

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to increase the direct supervision of the resident when the approaches of call light in reach and alarms were ineffective to prevent unassisted transfers and unsupervised ambulation resulting in a fall when the resident repeatedly attempted to rise without assistance. The resident was not supervised when diuretic and laxative medications were added to the medication regimen, and when the resident was emotionally upset. The deficient practice affected 1 of 3 residents reviewed related to falls in a sample of 3. (Resident C) Resident C experienced a fall after unassisted rising, which resulted in a laterally displaced type-3 odontoid fracture to the cervical spine and a laceration at the eyebrow requiring repair with sutures. Findings include: The clinical record for Resident C was reviewed on 1/12/12 at 1:30 p.m. The record indicated the resident was admitted to the facility on 11/10/11 from a rehabilitation hospital following aftercare for pelvic fracture and encephalopathy.	F0323	This plan of correction constitutes Providence Retirement Home's credible allegation of compliance for thecited deficiency. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during complaint survey.1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Unable to correct for Resident #C. Upon discharge from facility, resident was transferred to an out of state hospital.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;DON/Designee will audit all residents with bed/chair alarms for appropriate interventions with their current status.3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Nursing staff will be in-serviced on identifying appropriate interventions and updating care plan.Director of Nursing/Designee	02/10/2012

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	The "Morse Fall Scale" used to assess risk for falls, with a score equal to or greater than 25 indicating risk for fall, indicated the following assessments: 11/10/11: 45; 11/13/11: 60; 11/18/11: 45; 12/2/11: 60; and 12/16/11: 60. All of the assessments indicated a history of falling, with an immediate fall or history of falling within three months and impaired gait/transferring. The assessments on 11/13/11, 12/2/11, and 12/16/11 also indicated, "Mental status: Forgets limitations." Nurse's Notes on 11/13/11 at 5:05 p.m., indicated, "Visitor approached desk & advised Res [resident] in [room number] was lying on floor, entered room, res supine at foot of bed on floor, advised she was going to trailer....Late Entry @ 5:20 p.m. alarms checked turned off by resident, stated she wasn't sure. [sic]" The Admission Fall Care Plan, dated 11/10/11, indicated the following approaches were check marked as applicable: "Keep call light and frequently used items in place, Non-skid footwear, Complete Fall Risk Assessment, Use of Alarm/Equipment (Type) Pressure sensor alarm @ all X's [times], Therapy or Restorative as indicated, Dycem sheets layered above &		will audit 20% of resident population identified as a fall risk for appropriate interventions weekly for one month then monthly for the remainder of the year.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program wil be put into place;Director of Nursing/Designee will audit 20% of resident population identified as a fall risk for appropriate interventions weekly for one month then monthly for the remainder of the year. Findings will be reported to the QI committee.	

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	below alarm while [arrow pointing up] in chair/W/C [wheel chair]." Nurse's Notes for December 2011 indicated the following: 12/7/11 at 9:41 p.m., "...Several attempts to self ambulate this p.m. [evening] [symbol for with] alarms in place & funct [functioning]. Ignores all alarms & verbal education on the importance of alarms & amb [ambulation] [symbol for with] assist - Call lt [light] [symbol for with] in reach makes [symbol for no] attempt to use it." 12/10/11 at 9:40 p.m., "...Res [resident] confused this shift @ times, transferred self [symbol for without] use of call light, pt [patient] teaching given in regards to assist [symbol for with] transfers...." 12/13/11 at 9:21 p.m., "...Self ambulated X [times] 2 this p.m....Non-compliant to alarms stated 'I'm trying.'" 12/16/11 at 6:45 a.m., "...Res slept all noc [night] [symbol for without] diff [difficulty]. Res did get [arrow pointing up] OOB [out of bed] X i [one] [symbol for without] assist, alarm was sounding and res had walked self to the bathroom this nurse waited for res to finish and walked [symbol for with] her back to bed. Gait slow/steady. Alarm in place & funct.			

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	[functioning] properly. Call light [symbol for with] in reach...." 12/19/11 at 1:31 p.m., indicated the physician was contacted related to "3+ edema to BLE [bilateral lower extremities], and a new order was received for Lasix (diuretic) daily. 12/19/11 at 9:30 p.m., indicated the resident complained of no bowel movement and discomfort in the rectal area. The physician was contacted and orders were received for enemas and Dulcolax suppositories as needed and a stool softener daily. The Note indicated, "Prune juice given X 2 - enema given tolerated well [symbol for with] med [medium] soft bowel...." 12/20/11 8:00 p.m. "...Res cont [continues] to have +2 edema BLE [bilateral lower extremities]...XL [extra large] bowel movement this shift...Sensor alarm on & functioning properly. Several attempts to stand up. Re-educated about using call light." The Medication Administration Record indicated the diuretic was administered on 12/19 and 12/20/11 at 4:00 p.m., and Miralax (stool softener) was administered on 12/21/11 at 8:00 a.m.			

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	The Physical Therapist Progress Report and Discharge Summary, dated 12/21/11, indicated the following: "Gait tasks: Assistive Devices - Current Level of Function: The patient requires front wheeled walker and CGA [contact guard assist] to SBA [stand by assist] for safe ambulation for 100 feet X 2 with cues for safety technique; Standing Balance: General - The patient demonstrates standing balance of poor to fair dynamic and maintains for 5 - 10 minutes requiring CGA to SBA; Transfer: General - The patient is able to safely complete all functional transfers requiring CGA to SBA." "Patient/Caregiver Training" indicated, "Res needed cont [continuous] verbal cues for safety." "Impact on Burden of Care/Daily Life: Needed CGA to SBA for safety." "Precautions: Fall risk, WBAT [weight bearing as tolerated]." The Social History and Assessment, dated 11/26/11, indicated the resident was alert to person and time, had good to fair long term memory, and poor short term memory. Social Service Progress Notes indicated the following: 11/18/11 (untimed), "...She has struggled with unsafe transfers when she feels staff			

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	do not respond quick enough to her call light...." 11/26/11 (untimed) , "Resident's behaviors continue with...unsafe transfers...." Social Service Progress Notes for 12/21/11 at 11:30 a.m., indicated the social worker met with the resident and her power of attorney (POA) about the resident's plans for discharge. The resident was told by her POA that she would be unable to afford to return home and pay for full time caregivers. The Notes continued, "Res. was worried about d/c [discharge] plan & upset that she couldn't return hm [home]. Sat [symbol for with] res [resident] 1:1 [one on one] for 15 min [minutes] [symbol for with] [name of POA] @ other side of bed until she stopped crying & began to go to sleep. [Name of POA] was in rm [room] when this writer left. Alerted the nurse of resident's concerns & requested a f/u [follow up]...." Nurse's Notes on 12/21/11 at 12:55 p.m. indicated, "Res call light sounded. This nurse left desk to answer call light . As this nurse approached room, alarm sounding. As this nurse approached room, res found laying on bathroom floor [symbol for with] pants pulled down, head			

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	on floor laying on L [left] side. Asked CNA to call supervisor office. Supervisor arrived to assess situation." The Notes were signed by LPN #7. Nurse's Notes on 12/21/11 also at 12:55 p.m. indicated the following: The resident was lying face down with arms at side and blood on the floor. The resident closed the eyes tightly when her name was called. The floor nurse was asked to call 911. During assessment, the resident stopped breathing and had no pulse. The resident was log rolled to her back, and pulse and respirations were absent. CPR was initiated. Emergency technicians (EMTs) arrived, a pulse was detected, and an endotracheal tube was placed. The resident was transferred to the local hospital. The Emergency Department report, dated 12/21/11 indicated, "...CT [computerized tomography] scan of cervical spine reveals evidence of laterally displaced type-3 odontoid fracture....The wound to the patient's eyebrow was...closed with running 6-0 Ethilon suture." The report indicated the resident was to be transferred to an out of state hospital for further evaluation. During interview completed on 1/13/12 at 2:05 p.m., LPN #7 indicated the			

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	following: She was caring for Resident C on 12/21/11 when the resident fell. The resident used her call light, and she (LPN #7) left the nurse's desk to answer the call light. She heard the alarm sounding, and the resident was on the floor in the bathroom. She asked the CNA to call the supervisor who came immediately and began assessing the resident. LPN #7 left the room to call 911. LPN #7 indicated Resident C was the type of resident who used the call light and then immediately got up out of her chair instead of waiting for assistance. This federal tag relates to Complaint IN00101601. 3.1-45(a)(2)			